DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-009

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42CFR447.253

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 0
b. FFY 2004 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A pages 1 - 4, 16, 17, 20, 21a, 21b, 22

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A pages 1 - 4, 16, 17, 20, 21a, 21b, 22

10. SUBJECT OF AMENDMENT:
Inpatient hospital rates.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
As per Governor's letter dated Dec 14, 1999

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Vivianne M Chaumont

13. TYPED NAME:
Vivianne Chaumont

14. TITLE:
Director, Medical Assistance Office

15. DATE SUBMITTED:
June 3, 2003

16. RETURN TO:
Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Trish Bohm

[redacted]

METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES - INPATIENT HOSPITAL SERVICES

PAYMENT METHODS FOR HOSPITALS

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

Definitions:

1. Diagnosis Related Group (DRG): A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.

   Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

   a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.

   b. Rehabilitation and Specialty-Acute Hospitals: all hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).

   c. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).

   d. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

   Facilities which do not fall into the peer groups described in a. or b. will default to the peer groups described in c. and d. based on geographic location

5. Medicare Base Rate: The hospital specific Medicare base rate, which will be obtained directly from the Medicare Intermediaries, represents the payment a hospital would receive from Medicare for a DRG with a weight equal to one. The Medicare base rate used for rate setting each State Fiscal Year (July 1 through June 30) will be those effective on each October 1 prior to the beginning of the State Fiscal Year.

6. Disproportionate Share Hospital (DSH) factors: These factors are specific payments made by Medicare to Disproportionate Share Hospitals within the Medicare base rate. The operating and capital Disproportionate Share Hospital factors will be obtained from the Medicare Intermediaries. The operating Disproportionate Share Hospital factor is multiplied by the federal portion of the operating subtotal to get the operating Disproportionate Share Hospital amount. The capital Disproportionate Share Hospital factor is multiplied by the capital portion of the federal payment to get the capital Disproportionate Share Hospital amount.

7. Budget Neutrality: Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The

estimated hospital specific payments is calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate.

8. Medicaid Base Rate or Base Rate: An estimated cost per Medicaid discharge.

For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals, including Rehabilitation and Specialty-Acute Hospitals.

For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education. The estimated cost per discharge amount for Nursery and Neo-Natal Intensive Care Units will be calculated by multiplying the Medicare hospital specific base rate, without DSH, by the ratio of Medicaid Nursery or Neo-Natal costs to total Nursery or Neo-Natal costs respectively. A cost per discharge amount for Graduate Medical Education will be obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

Pediatric Specialty Hospitals will receive an additional adjustment factor of 1.335 to account for the specialty care provided. This adjustment factor will not be applied to the Medicaid cost add-ons.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be the Medicare TEFRA rate from the most recently audited Medicare/Medicaid cost report (CMS 2552) divided by the Medicaid case mix index and then modified by a set percentage equally for all PPS Rehabilitation and Specialty-Acute Hospitals. The percentage will be the percentage used to modify the Medicare base rate of all other PPS hospitals multiplied by 1.397. The Medicare/Medicaid cost report and Medicaid case mix index used for this calculation will be those available as of March 1 each year.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 60 days prior to any adjustment in the payment. Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Exempt hospitals are those hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system. The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS). Exempt hospitals will be paid a per diem for inpatient hospital services. As of July 1, 2003 free-standing psychiatric facilities shall be the only exempt providers.

9. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94. standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

10. Infant Cost Outlier. To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%, the Medicare rate) rather than to establish a separate cost outlier mechanism.

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Under no circumstances shall the annual weighted average increase in cost within any peer group driven by this calculation exceed a 7% limit.

4. The annual inflator is subject to changes in appropriations made by the General Assembly and the annual inflator may be adjusted by the Department accordingly. Prior to the start of the State Fiscal Year providers will receive a letter from the Department describing how the rate, including inflation, was calculated.

C. On the third year (July, 1993) rates shall be calculated based upon the audited cost reports available for each facility for FYE 12/31/90. If the audited cost data show that the annual inflators were too high, or if they show the inflators were too low, the actual cost from the reports available for FYE 12/31/90 shall be used. There shall be NO retrospective changes to the rates if/when the "third year" rebased rates show that the 7% annual inflator was inaccurate.

D. Beginning July, 1993, rates shall be recalculated or rebased every third year and the annual inflator shall be used to increase the rates in the interim years.

E. In rebasing years, the initial base rate for pediatric specialty hospitals will be attributed to the routine, ancillary, capital, and medical education cost centers, proportionally, based on the actual costs from the most recently audited cost report. The cost per discharge for the medical education cost center, which is capped at 100 percent, will be deducted from the initial base rate and the reminder will be attributed to the other three costs centers in proportion to actual costs. These figures, which will add up to the total base rate, will represent the pediatric specialty hospital peer group caps for the routine, ancillary, and capital cost centers. These figures will be used as the starting point for subsequent payment cap adjustments as described in the previous definition of Base Rate.

F. Effective July 1, 2003 all adjustments outlined in number 2. of this section (Adjustments To The Payment Formula) are suspended.

Adjustments For Exempt Providers:

1. A. Effective for dates of service after July 1, 1991, exempt hospitals will receive annual modifications to per diem rates. Based on hospital-specific annual projected inpatient cost increases and changes in consumer price index, per diem rate increases or decreases will be authorized subject of a maximum increase of 7% annual limit. Beginning in July, 1993, and for future PPS hospital rebasing periods, the maximum amount of any cost increase granted to an exempt facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for the State fiscal year 1994 and for every year thereafter when PPS hospital base rates are recalculated. In no case, shall the per diem rate granted to an exempt hospital exceed the facility's Medicaid cost per day.

   B. Exempt hospitals which are government owned mental health institutes. Effective October 1, 2001, government owned mental health institutes shall receive annual modifications to the per diem rates. The rates shall be established to cover one hundred per cent of the total allowable cost to treat Medicaid clients. These rates shall be based on annual cost reports submitted by the mental health institutes. These cost reports will be subject to annual audits. The audited allowable costs shall be used to set the basis for the retroactive rate which will be effect for the same period covered by the cost report. At the beginning of each cost reporting period, the mental health institute may submit a hospital specific, projected inpatient pre diem cost amount which may be used to set an interim rate for the following cost reporting period. The interim rate shall be adjusted to equal the audited allowable per diem cost for the Medicaid clients. This amount is established through audit. The ceilings and cost limit increases specified in paragraph A of this section shall not apply to these facilities.

2. Exempt hospitals are eligible for the Major Teaching Hospital and Disproportionate Share Payments.

Adjustments For Out-of-State Providers:

1. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid patient must be prior authorized by the Department, based upon review and recommendation by the Peer Review Organization (PRO).

2. Payment for out-of-state and non-participating Colorado Hospital inpatient services shall be at a rate equal to 90% of the average Colorado Urban or Rural DRG payment rate. Out-of State urban hospitals are those hospitals located within the Metropolitan Statistical Areas (MSA) as designated by the U.S. Department of Health and Human Services.

3. Effective January 1, 1992: When needed inpatient transplant services are not available at a Colorado Hospital, payment can be made at a higher rate (than 90% of the average Colorado Urban or Rural DRG payment rate) for non-emergent services if the provider chooses this payment method. When not reimbursed at a DRG payment rate the out-of-state hospital will be paid based upon the following criteria:

   a. Payment shall be 100% of audited Medicaid costs.

   b. In no case shall payment exceed $1,000,000 per admission.

4. All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical, and financial data to the Colorado Hospital Association Date Bank Program. If a hospital does not report to the Colorado Hospital Association Data Bank, the State agency will send the required format for reporting this data.

Free Standing Psychiatric Hospitals (Excluding State Institutions):

1. Effective October 10, 1998, new payment rates for care provided to Medicaid patients under 21 in Cedar Springs Psychiatric Hospital, Centennial Peaks Hospital, and Cleo Wallace Center have been established. The Department analyzed historical Medicaid payment rate data and evaluated the nature of the relationship between hospital cost data and patient length of stay information. Fiscal Year 1987 Medicaid cost data from the participating facilities was used to determine the break points within the 42 day average length of stay, where costs differ substantially. This 1987 data revealed that costs for the first seven days of care were 38% higher than costs for the remainder of the certified stay. Based upon this cost relationship, the existing per diem payments made to these facilities were recalibrated to reflect a "step down" in payment after day 7. The two per diem rates, when paid for the entire 42 day average length of stay, will pay an average amount equal to previous payments to these facilities. Thus, the revision in payment methodology was designed initially to be revenue neutral while providing further incentives for cost containment.

2. For certified days of care in which the patient is awaiting transfer to a more medically appropriate treatment setting outside of the hospital inpatient facility, the Colorado maximum RCCF (Residential Child Care Facility) rate will initially be paid.

3. Effective December 15, 1989, these free-standing psychiatric hospital rates will be updated annually by the methodology outlined in number 1. in the Adjustments For Exempt Providers section above.

4. Effective July 1, 1989 Cedar Springs Psychiatric Hospital was terminated as a Colorado Medicaid provider. Effective December 8, 1990 La Plata Psychiatric Hospital became eligible for reimbursement as a Colorado Medicaid provider. Effective July 1, 2002 PSI Cedar Springs Hospital, Inc. became eligible for reimbursement as a Colorado Medicaid provider.